Appendix C: Participant Services

C-1: Summary of Services Covered (1 of 2)

a. Waiver Services Summary. *List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:*

Service Type	Service
Statutory Service	Care Coordination
Statutory Service	Day Habilitation
Statutory Service	Residential Habilitation
Statutory Service	Respite
Statutory Service	Supported Employment
Other Service	Chore
Other Service	Environmental Modifications
Other Service	Intensive Active Treatment
Other Service	Meals
Other Service	Specialized Medical Equipment & Supplies
Other Service	Transportation

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Statutory Service

Service:
Case Management

Alternate Service Title (if any):
Care Coordination

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Care coordinators assist individuals who apply for an HCB Waiver gain access to needed waiver and other State Plan services, as well as needed medical, social and other services. Once a person is approved for a waiver, ongoing care coordination services include routine monitoring to ensure the scope, amount, frequency and duration of services are provided as established in the recipient's Plan of Care. Care coordinators are charged to meet with each recipient at least twice a month to review existing services, monitor quality of care, and make Plan of Care revisions as they are necessary. Care coordinators initiate and oversee the annual process of renewing the plans of care.
See 7 AAC 43.1041 for further description.
Care Coordination is billed at 1 unit per month, up to 12 units per year. Plan of care development is authorized for payment once a year unless authorized more frequently based on the recipient's change of status.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Care Coordination is billed at 1 unit per month, up to 12 units per year. Plan of care development is authorized

for payment once a year unless authorized more frequently based on the recipient's change of status.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Care Coordinator
Agency	Care Coordination Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Care Coordination

Provider Category:
Individual
Provider Type:
Care Coordinator
Provider Qualifications
License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
DSDS Provider Standards
Verification of Provider Qualifications
Entity Responsible for Verification:
DSDS Provider Certification Section
Frequency of Verification:
Upon initial application, CC Supervisor as new staff fill the position.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Care Coordination

Provider Category:
Agency
Provider Type:
Care Coordination Agency
Provider Qualifications
License *(specify)*:

Certificate *(specify):*

Other Standard *(specify):*
As certified under 7 AAC 43.1090

Verification of Provider Qualifications

Entity Responsible for Verification:
DSDS Provider Certification Section

Frequency of Verification:
Every 2 years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Statutory Service

Service:
Day Habilitation

Alternate Service Title (if any):

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Day habilitation is assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills which takes place in a non residential setting, separate from the home or facility in which the individual resides.

Day habilitation services focuses on enabling the recipient to attain or maintain his or her maximum functional level, is coordinated with any physical, occupational, or speech therapies listed in the plan of care and may serve to reinforce skills or lessons taught in school, therapy or other settings.

Day habilitation may not replace, enhance or supplement education services for which the recipient is eligible for under 7 AAC 52.
Se 7 AAC 43.1045 for further description

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
None

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

- [ ] **Legally Responsible Person**
- [ ] **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	HCB Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Day Habilitation

Provider Category:
Agency

Provider Type:
HCB Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Qualified provider agency as determined under 7 AAC 43.1090

Verification of Provider Qualifications

Entity Responsible for Verification:
DSDS Provider Certification Section

Frequency of Verification:
Every 2 years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Statutory Service

Service:
Residential Habilitation

Alternate Service Title (if any):

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ◉ **Service is included in approved waiver. There is no change in service specifications.**
- ○ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Assistance with acquisition, retention, or improvement in skills related to activities of daily living, such as personal grooming and cleanliness, bed making and household chores, eating the preparation of food, and the social and adaptive skills necessary to enable the individual to reside in a non institutional setting. Payments for

residential habilitation are not made for room and board, the cost of facility maintenance, upkeep and improvement, other than such costs for modifications or adaptation to a facility required to assure the health and safety of residents, or to meet the requirements for the applicable life safety code. Payment for residential habilitation does not include payments made directly or indirectly to members of the individual's immediate family. Payments will not be made for the routine care and supervision which would be expected to be provided by a family or group home provider, or for activities or supervision for which a payment is made by a source other than Medicaid.

See 7 AAC 43. 1046 for further description
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
none

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	HCB Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Residential Habilitation

Provider Category:
Agency
Provider Type:
HCB Agency
Provider Qualifications
License *(specify):*
Foster home license under 47.35 for recipients under age 18 years.(The home must hold a valid license meeting the health and safety standards of a foster home, recipients living in the home are not required to be in State custody to receive habilitation services in the licensed home)

Assisted living home license under AS 47.33 for recipients age 18 years or older.
Certificate *(specify):*

Other Standard *(specify):*
Qualified provider agency as determined under 7 AAC 43.1090
Verification of Provider Qualifications
Entity Responsible for Verification:
DSDS Provider Certification Section

Assisted Living Home license under AS 47.33, issued by the Department of HHS/Division of Public Health Certification and Licensing Unit.

Foster Home License under AS 47.35, issued by the Department of HSS/Office of Childrens Services.

Frequency of Verification:
Every 2 years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Statutory Service

Service:
Respite

Alternate Service Title (if any):

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (•) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Respite care is a service that may be provided to relieve primary unpaid caregivers of waiver recipients.
DSDS will not reimburse for respite services to allow a primary caregiver to work, provide oversight for additional minor children in the home, or relieve other paid providers of Medicaid services except for providers of family habilitation services.
DSDS will reimburse for room an board expenses of the recipient incurred during the provision of respite care services only if the room and board are provided in a nursing facility, an acute care hospital, an ICF/MR, a licensed assisted living home or licensed foster home that is not the recipient's residence.
See 7 AAC 43.1049 for further description.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Under 7 AAC 43.1049: Hourly respite is limited to 520 hours per year.
Per diem respite is limited to 14 days per year.

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	HCB Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency
Provider Type:
HCB Agency
Provider Qualifications
License *(specify):*
Per diem providers must also be licensed as an assisted living home (for recipients 18+ years old) under AS 47.33; or a licensed foster home (for recipients under 17 years) under AS 47.35.
Certificate *(specify):*

Other Standard *(specify):*
Qualified provider agency as determined under 7 AAC 43.1090
A residence providing per diem respite must hold a valid license meeting the health and safety standards of a foster home or assisted living home. Recipients receiving per diem respite in the home are not required to be in State custody to receive this service in the licensed home)
Verification of Provider Qualifications
Entity Responsible for Verification:
DSDS Provider Certification Section
Frequency of Verification:
HCB Agency is reviewed every 2 years

Foster Home license must be renewed annually.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Statutory Service
Service:
Supported Employment
Alternate Service Title (if any):

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Supported employment services consist of paid employment for people for whom competitive employment at or above the minimum wage is unlikely, and who, because of their disabilities, need intensive ongoing support to perform in a work setting. Supported employment is conducted in a variety of settings, particularly work sites in which people without disabilities are employed. Supported employment includes activities needed to sustain paid work by individuals receiving waiver services, including supervision and training. When supported employment services are provided at a worksite in which people without disabilities are employed, payment will be made only for the adaptations, supervision and training required by individuals receiving waiver services as a result of their disabilities, and will not include payment for the supervisory activities rendered as a normal part

of the business setting.

Supported employment services furnished under the waiver are not available under a program funded by either the Rehabilitation Act of 1972 or P.L. 94-142.

See 7 AAC 43 1047 for further description.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
none

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	HCB Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Supported Employment

Provider Category:
Agency
Provider Type:
HCB Agency
Provider Qualifications
License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
Qualified provider agency as determined under 7 AAC 43.1090
Verification of Provider Qualifications
Entity Responsible for Verification:
DSDS Provider Qualifications Section
Frequency of Verification:
Every 2 years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Chore

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (•) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Chore services includes performing heavy household chores including washing floors, windows and walls; tacking down loose rugs and tiles; moving heavy items of furniture; snow shoveling in order to provide safe access and egress; regular cleaning within the residence used by the recipient; other services the department determines necessary to maintain a clean, sanitary and safe environment for the recipient. Payment for chore services will not be made if the recipient or anyone else in the household is capable of performing or financially providing for them, or any other relative or caregiver of the recipient, or any community or volunteer agency or third party payer is capable of or responsible for the provision of those services.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
5 hours per week unless the recipient has a documented history of respiratory illness, then the department will reimburse up to 10 hours per week.

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	HCB Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Chore

Provider Category:
Agency
Provider Type:
HCB Agency
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Qualified provider agency as determined under 7 AAC 43.1090

Verification of Provider Qualifications

Entity Responsible for Verification:
DSDS Certification Section

Frequency of Verification:
Every 2 years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Environmental Modifications

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (•) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Environmental modification services are physical adaptations to the recipient's home, as identified in the Plan of Care, that are necessary to ensure the health, welfare, and safety of the recipient. The cost of all environmental modification services for a recipient include the cost of labor, building materials, parts, supplies, permits, demolition and other goods that are necessary to accomplish the modifications in the recipients home. $10,000 per 36 may not be exceeded except if the excess is for repair or replacement of a previous environmental modification (not to exceed $500 per year of the remaining 36 month period); results solely from the cost of freight to deliver materials and supplies to a rural community; or provides an administrative fee under 7 AAC 43.1058 if the provider is an OHCDS under 42 CFR 447.10. Once the HCB Service provider that received the prior authorization has been paid in full, the environmental modification will be considered complete.

Not accepted as environmental modifications are: modifications that increase the square footage of an existing residents, are parts of a larger renovation to an existing residence or are included in construction of a new residence; general utility adaptations, modifications or improvements to the existing residence; adaptations, modifications or improvements to the exterior of the dwelling including outbuildings, yard, driveways and fences, except for adaptations, modifications or improvements to doors, exterior stairs and porches necessary for egress for the recipient.
Find 7 AAC 43.1054 Environmental Modifications for complete description.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Environmental modifications may not exceed $10,000 per recipient in a continuous 36 month period.

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Environmental Modifications Agency
Agency	HCB Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Environmental Modifications

Provider Category:
Agency

Provider Type:
Environmental Modifications Agency

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
State of Alaska Contractor's License AS 47.08 . Qualified EM Provider Agency as determined under 7 AAC 43.1090

Verification of Provider Qualifications

Entity Responsible for Verification:
DSDS Provider Certification Section

Frequency of Verification:
Every 2 years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Environmental Modifications

Provider Category:
Agency

Provider Type:
HCB Agency

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
Qualified provider agency as determined under 7 AAC 43.1090

Verification of Provider Qualifications

Entity Responsible for Verification:
DSDS Provider Certification Section

Frequency of Verification:
Every 2 years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Intensive Active Treatment

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*
In accordance with 7 AAC 43.1048, intensive active treatment services are services provided by or under the supervision of a licensed professional to a recipient who needs immediate intervention to decelerate a medical condition or behavior regression that, if left untreated, would place the recipient at risk of institutionalization. The department will consider services to be intensive active treatment services if the department determines them to provide specific treatment or therapy, in order to maintain or improve effective functioning of the recipient; each intervention requires the precision and knowledge possessed only by specifically trained professionals in specific disciplines, whose services are not covered under Medicaid or as habilitation services under 7 AAC 43.1045 - 7 AAC 43.1046; and the treatment or therapy is designed and provided by a professional licensed under AS 08 with expertise specific to the diagnosed condition, or by a paraprofessional licensed under AS 08 if necessary and supervised by that professional.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
None

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	HCB Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Intensive Active Treatment

Provider Category:
Agency
Provider Type:
HCB Agency
Provider Qualifications
License *(specify):*
Professional license or paraprofessional under AS.08
Certificate *(specify):*

Other Standard *(specify):*
Qualified provider agency as determined under 7 AAC 43.1090
Verification of Provider Qualifications
Entity Responsible for Verification:
DSDS Provider Certification Section
Frequency of Verification:
Every 2 years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Meals

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (•) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Nutritious meals may be provided to a recipient 18 years of age or older.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
A maximum of two (2) meals per day are available for recipients over age 18. A full meal regime is prohibited.

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [ ] **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	HCB AGency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Meals

Provider Category:
Individual

Provider Type:
HCB AGency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Qualified provider agency as determined under 7 AAC 43.1090

Verification of Provider Qualifications

Entity Responsible for Verification:
DSDS Provider Certification Section

Frequency of Verification:
Every 2 years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Specialized Medical Equipment & Supplies

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ◉ **Service is included in approved waiver. There is no change in service specifications.**
- ○ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Specialized Medical Equipment (SME) and supplies are devices, controls or appliances that enable a recipient to increase their ability to perform activities of daily living or to perceive, control or communicate with the environment in which the recipient lives; or ancillary supplies and equipment necessary for the proper functioning of those items. The department will not reimburse items defined under regular Medicaid equipment

or supplies. SME must be rented if renting the equipment is more cost-effective than purchasing it. SME will not reimburse for hot tubs, spas, saunas, or permanently installed hydrotherapy devices; developmental toys; personal computers, other computer hardware, peripherals, computer software, personal data assistants, or cellular telephones; outdoor playground equipment, scissors lifts, bicycles, other pedal-driven devices, or exercise equipment; lights or other devices used to treat seasonal affective disorder; vacuum cleaners or household appliances; devices that receive, record, or play audio or video in any medium, including TV, compact disc players, MP3 players, videocassette players and DVD players; micro cars or adaptive clothing.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
None other than those above

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Medical Supply Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Specialized Medical Equipment & Supplies

Provider Category:
Agency
Provider Type:
Medical Supply Provider
Provider Qualifications
License *(specify)*:
Alaska Business License
Certificate *(specify)*:
Other Standard *(specify)*:
Medical Supply Provider enrolled directly with SMA
Verification of Provider Qualifications
Entity Responsible for Verification:
State Claims Payment System
Frequency of Verification:
Annual

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Transportation

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (•) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Transportation services enable a recipient (and any necessary escort) served on the waiver to gain access to waiver and other community services, activities and resources specified by the Plan of Care. This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the State plan, defined at 42 CFR 440.179 (a) and shall not replace them. Transportation services under the waiver shall be explained in the recipient's plan of care. Whenever possible, family, neighbors, friends, or community agencies that provide this service without charge will be utilized.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
None

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	HCB Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transportation

Provider Category:
Agency
Provider Type:
HCB Agency
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Qualified provider agency as determined under 7 AAC 43.1090

Verification of Provider Qualifications

Entity Responsible for Verification:
DSDS Certification Section

Frequency of Verification:
Every 2 years

Appendix C: Participant Services

C-1: Summary of Services Covered (2 of 2)

b. **Alternate Provision of Case Management Services to Waiver Participants.** When case management is not a covered waiver service, indicate how case management is furnished to waiver participants (*select one*):

- ○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ○ **Applicable** - Case management is furnished as a distinct activity to waiver participants.

  Check each that applies

  - ☐ **As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
  - ☐ **As an administrative activity.** *Complete item C-1-c.*
- ○ **None of the above apply** (i.e., case management is furnished as a waiver service)

c. **Delivery of Case Management Services.** Specify the entity or entities that conduct case management functions on behalf of waiver participants:

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

a. **Criminal History and/or Background Investigations.** Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

- ○ **No. Criminal history and/or background investigations are not required.**
- ◉ **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

A. Current practice: HCB and Care Coordination Agencies provide written assurances to the State that all HCB Agency paid and volunteer employee who have any direct contact with Waiver recipients meet criminal background check standards under AS 47.05.017 at the time of HCB or Care Coordination Agency certification reference in 7 AAC 43.1090. This is updated once every two years after the initial check. Notify DSDS in writing of any criminal charge or conviction including restraining orders of any employee paid or volunteer within 24 hours of the incident or the next business day. DSDS staff will check Agency files during on site review to assure that employee files are in compliance with the requirement.

After July 1, 2006: HCB agencies will be required to provide proof of state and federal background investigations for all employees, paid and volunteer, providing home and community-based waiver services as part of the agency's initial application packet. Thereafter, every two years when the HCB Agency requests for

recertification to continue to provide services, the HCB agency must again provide this assurance. During the two-year period of certification, periodic onsite reviews by DSDS staff, triggered by complaints or other indicators, HCB agency employee files are reviewed to assure compliance with the requirement. Persons with barrier criminal activity (record of a crime that would prohibit providing services)are not permitted to provide paid or volunteer waiver services

Under State law, AS 47.05.017, persons providing waiver services must complete fingerprinting for a criminal background check within 10 days of being hired by a certified HCB agency. This report is conducted through the Department of Public Safety for state review and the FBI for federal review. The certified HCB agency must review the criminal background report within five business days after it has been received. The HCB agency is required to notify the State DSDS in writing of any criminal or civil charge or conviction, including restraining orders, of any employee paid or volunteer, within 24 hours or the next business day of the incident. DSDS staff reviewing a problematic report advises the HCB agency accordingly. Background checks must be updated every two years for all persons providing direct waiver services.

The State will not authorize certification or recertification of providers in violation of the criminal background check requirement. Persons failing to meet requirements are not allowed to provide waiver services.

B. Current practice: An abuse registry screening does not yet exist in Alaska. Each applicant for each HCB agency must present proof of a criminal background checks. There is no centralized registry providing this information.

After July 1, 2006: Effective March 1, 2006, AS 47.05.300 – 47.05.390 Criminal History Registry - became effective. This statute requires the Department of Health and Social Services to maintain a centralized registry for the entire State Medicaid Agency. The Division of Public Health, Background Check Unit will maintain the registry. Regulations to implement this Statute have been out for public comment and are anticipated to be effective July 1, 2006. Until the new system is implemented, the present practice will be used.

b. **Abuse Registry Screening.** Specify whether the State requires the screening of individuals who provide waiver services through a State-maintained abuse registry (select one):

- ○ **No. The State does not conduct abuse registry screening.**
- ◉ **Yes. The State maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Current Practice: There is no abuse registry. Each potential employee with each HCB agency, who would provide direct services to HCB recipients, must undergo a criminal background check. At this time the State of Alaska does not have a master list of individuals who have not passed the background check. The State of Alaska does maintain a list of individuals (sexual offenders, certified nursing assistants and the State name check) in the state that is checked. At the present time, we accept signed assurances from HCB Agencies that criminal background checks have been complete and are on file.

After July 1, 2006: The State abuse registry will maintained through the Department of Health and Social Services Division of Public Health, which maintains the list for the entire State Medicaid Agency and is described above. Until the time the State abuse registry is functional, the current practice will be followed as described in (a).

State Law AS 47.05.017 dictates that, "State money may not be used for a home care provider unless criminal history record information as permitted by P.L. 105-277 and AS 12.62 is requested for the provider within 10 business days after the provider is hired to provide the care and is reviewed within five business days after it is received. The department shall require the grantee or contractor to do the information request and review required under this subsection for a home care provider employed by a person who has a grant or contract from the department to provide home care services."

Public home care providers described in AS 47.05.017 "means a person who is paid by the state, or by an

entity that has contracted with the state or received a grant from state funds, to provide homemaker services, chore services, personal care services, home health care services, or similar services in or around a client's private residence or to provide respite care in either the client's residence or the caregiver's residence or facility," providers of home and community-based waiver services, personal care attendants and individuals or entities who are required by statute or regulation to be licensed or certified by the department.

Criminal background checks are required in accordance with the State abuse registry are required of the following paid and volunteer workers with directed direct contact with waiver recipients : care coordinator, respite, residential habilitation, adult day services, day habilitation, supported employment, chore, assisted living, transportation and intensive active treatment.

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one:*

- ○ **No. Home and community-based services under this waiver are not provided in facilities subject to §1616 (e) of the Act.**
- ◉ **Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

i. Types of Facilities Subject to §1616(e). Complete the following table for each type of facility subject to §1616(e) of the Act:

Facility Type
Licensed Assisted Living Home
Licensed Foster Home

ii. Larger Facilities: In the case of residential facilities subject to §1616(e) that serve four or more individuals unrelated to the proprietor, describe how a home and community character is maintained in these settings.

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Licensed Assisted Living Home

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Intensive Active Treatment	☑
Day Habilitation	☑
Respite	☐
Environmental Modifications	☐

Specialized Medical Equipment & Supplies	☑
Meals	☐
Supported Employment	☑
Residential Habilitation	☑
Transportation	☐
Care Coordination	☑
Chore	☐

Facility Capacity Limit:

2

Scope of Facility Sandards. For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☑
Physical environment	☑
Sanitation	☑
Safety	☑
Staff : resident ratios	☑
Staff training and qualifications	☑
Staff supervision	☑
Resident rights	☑
Medication administration	☑
Use of restrictive interventions	☑
Incident reporting	☑
Provision of or arrangement for necessary health services	☑

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Licensed Foster Home

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Intensive Active Treatment	☑
Day Habilitation	☑
Respite	☑
Environmental Modifications	☐
Specialized Medical Equipment & Supplies	☑
Meals	☐
Supported Employment	☑
Residential Habilitation	☐
Transportation	☑
Care Coordination	☑
Chore	☑

Facility Capacity Limit:

Not applicable under 7 AAC 43.1046 not more than two CCMC recipients may reside in the same out-of-home placement (unless an exception is made to accommodate sibling groups).

Scope of Facility Sandards. For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☑
Physical environment	☑
Sanitation	☑
Safety	☑
Staff : resident ratios	☑
Staff training and qualifications	☑
Staff supervision	☑
Resident rights	☑
Medication administration	☑
Use of restrictive interventions	☑
Incident reporting	☑
Provision of or arrangement for necessary health services	☑

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one*:

- (●) **No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- ( ) **Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.*

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

- (●) **The State does not make payment to relatives/legal guardians for furnishing waiver services.**
- ( ) **The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

- ( ) **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

- ( ) **Other policy.**

Specify:

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

The process of continuous, open enrollment of providers is covered under 7 AAC 43.1090 Provider certification and enrollment. The provider certification packet referenced in this regulation contains information regarding enrollment qualifications, requirements and procedures to qualify, as well as the timeframes established for qualifying and enrolling in the program. The packet available is on-line at Home and Community Based Waiver Services Certification Application Packet or a hard copy may be obtained by request.
All qualified providers are certified by DSDS. Applicants denied enrollment may reapply at any time.

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. **Additional Limits on Amount of Waiver Services.** Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

- ○ **Not applicable** - The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.
- ◉ **Applicable** - The State imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

- ☐ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
  Furnish the information specified above.

- ☐ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
  Furnish the information specified above.

- ☐ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
  Furnish the information specified above.

- ☑ **Other Type of Limit.** The State employs another type of limit.
  Describe the limit and furnish the information specified above.

Service limitations are in services that are not usually critical to home and community based care. Out of home placements are allowed 365 days per year. Residential Habilitation: In home support services are

not limited by hours/day or days/week. Adult day services, day habilitation, supported employment, transportation have no services limitations. Meals are limited by federal definition. Personal Care Assistance (PCA) – thought it is not a waiver service – can be used to fill in if needed. If necessary, DSDS would assists an individual to move into a licensed assisted living home to receive Residential supported living services, or the insitutional alternative of a nursing home, all the while knowing the recipient's wishes to move back home as the recipient's heath permits. DSDS has a full time staff member to assist moving people from nursing homes back into their community.

Should a recipient request more of services that are limited below than can be covered under these regulations, DSDS staff and care coordinators help recipients by increasing other HCB waiver services, adding regular Medicaid funded PCA, finding assistance through non-waiver community based programs, or grant services. The State has not had any requests for institutional placements based on a lack of chore services. If additional days of out of home respite are required, arrangements are made for nursing home placement until the recipient can return home. Effective approximately August 1, 2006 are regulations that will allow an increase in payment for HCB services in specific cases where health and welfare require increases in payment for services.

All recipients are advised of the service limitations through the care planning process, which occurs annually. The following have been employed by the State for waiver service limits. Each has been established in regulations.

Chore – 5 hours per week for all CCMC recipients, except that if an individual has documented respiratory illnesses, up to 10 hours/week may be approved. Limit was established July 1, 2004, established based on historical usage.
Respite – 520 hours of in home respite – limit based on historical usage prior to establishment of this limit. Limit was established in July 1, 2004, established based on historical, average usage.
Respite – maximum of 14 days of per diem respite – Limit was established July 1, 2004, established based on historical, average usage. Maximum reimbursement rose from $150 to $250 on July 1, 2005.
Environmental Modifications - $10,000 per 36 months – In place since 1994.
Care Coordination monthly fee - $200 per month - In place since 1994. As of July 1, 2005, care coordinators may bill for 12 months (up from 11 months per year).